STATE OF MAINE

DIRIGO HEALTH AGENCY

RE:	DETERMINATION OF AGGREGATE MEASURABLE COST SAVING FOR THE SECOND ASSESSMENT YEAR (2007)	))))))	AMENDED PRE-FILED TESTIMONY OF STEVEN P. SCHRAMM

Steven P. Schramm, called as a witness by the Dirigo Health Agency, testifies as follows:

Q: Please state your name, employer and business location.

A: My name is Steven P. Schramm. I am a Worldwide Partner in Mercer's Government Human Services Consulting Practice. My office is located in Phoenix, Arizona.

Q: Mr. Schramm, please describe your educational and professional background.

A: My educational and professional background is set forth in the attached curriculum vitae, Schramm Exhibit 1. The Government Human Services Consulting Practice is dedicated to helping publicly sponsored health and welfare programs become more efficient purchasers of health care services. As the senior strategist for the Government Human Services Consulting practice, I have been involved in the design, development, implementation, and evaluation of major statewide health care reform initiatives in the States of Arizona, Connecticut,

Kansas, Kentucky, Louisiana, Massachusetts, New Jersey, New Mexico, Pennsylvania, Tennessee, and now here in Maine.

Q: Mr. Schramm, please describe generally the work Mercer did on behalf of the Dirigo Health Agency.

A: Mercer assisted the Dirigo Health Agency establish the methodologies to be used for determining if there was any savings associated with Year 2 of the Dirigo program, including Dirigo's directly and indirectly related components, as described in the Dirigo Health Reform Act and related amendments. Our work with the Agency included examining the statute, cataloging the various impacts of Dirigo and Dirigo-related activities, identifying the associated populations and time frames impacted, and finally recommending proposed methodologies to capture those impacts. Mercer used the Year 1 savings methodologies and the guidance provided by the Superintendent of Insurance in his review of the Year 1 methodologies as our starting point for the Year 2 savings methodologies.

For Year 2 of Dirigo, we identified 9 initiatives in four major areas — Hospital Initiatives, Uninsured Initiatives, Certificate of Need/Capital Investment Fund Initiatives (CON/CIF), and Health Care Provider Fee Initiatives.

In Year 1, Dr. Nancy Kane, a professor of management with Harvard's School of Public Health, had primary responsibility for any hospital-related analysis due to her hospital financing expertise and previous work on behalf of Dirigo and the Hospital Study Commission. We relied heavily on her Year 1 analysis and

supplemented it based on the Superintendent's guidance with that of a State expert on Medicare Cost Reports (MCR) to fine-tune the cost per case-mix adjusted discharge (CMAD) savings methodology for Year 2. DHA also contracted with a Medicare Cost Report expert, Leonard Brauner of Sunstone Consulting, who Mercer worked with to validate the appropriate use of the MCRs in the CMAD savings methodology and to a lesser degree, on the uninsured savings methodology.

Mercer also consulted with a State expert on the State of Maine's Certificate of Need/Capital Investment Fund (CON/CIF) process to assist us in developing a savings methodology for CON/CIF. Working collaboratively with the various experts, Mercer developed savings methodologies for the Hospital Initiatives, Uninsured Initiatives, Certificate of Need/Capital Investment Fund Initiatives (CON/CIF), and Health Care Provider Fee Initiatives.

Mercer, utilizing the guidance provided by the Superintendent in his review of the Year 1 savings methodologies, reviewed each of the Year 1 savings methodologies and made changes to the Year 1 savings methodologies to improve their ability to estimate the impact of Dirigo upon the health care system in Maine. In performing and reviewing the calculations for the initiatives, we followed best practices in actuarial science, reviewed the reasonableness of assumptions and calculations, and performed calculations that were credible, easily replicable, and readily validated.

Q: Mr. Schramm, did Mercer prepare a report describing the saving methodologies to be used for estimating the impact of those 9 initiatives on behalf of the Dirigo Health Agency?

A: Yes — Mercer developed a report in March 2006 describing the savings methodologies (based on the data available at that time). It is being offered as Schramm Exhibit 2. Since that report was developed, additional data has become available. The Hearing Officer for the Board's hearing, scheduled for May 8th, has requested DHA, to the extent possible, provide calculations using those savings methodologies based on the data available. Mercer's calculations are attached in April 2006 DRAFT report that is being offered as Schramm Exhibit 3. The report is DRAFT as all of the data is not yet available and so Mercer, to the extent practical to meet the Hearing Officer's request, has provided estimates of the impact of Dirigo for the Board's use in determining aggregate measurable cost savings.

Q: Mr. Schramm, who was responsible for preparing Schramm Exhibits 2 and 3?

A: I had primary responsibility and was assisted by F. Kevin Russell, Actuary and Principal at Mercer, and other members of my Mercer team.

Q: Mr. Schramm, can you describe Mercer's approach to this project?

A: Mercer established a set of principles to guide us in developing the Year 2 savings methodologies. The guiding principles are as follows:

- Initiatives will be related to the Dirigo Health Reform Act, consistent with Public Law (PL) 2003, Chapter 469 and the methodologies themselves must be consistent with PL 2003 Chapter 469.
- To the extent possible, methodologies for Year 2 will be consistent with the guidelines provided by the Superintendent in regards to the Year 1 methodologies. Where appropriate, Mercer made changes to the guidelines suggested by the Superintendent and noted our changes accordingly.
- Initiatives are primarily voluntary. It is the role of the marketplace to voluntarily comply with savings targets and to recapture savings in price negotiations.
- Data sources, when available, must be readily available, verifiable and auditable, and to the extent possible, used for multiple purposes to ensure the accuracy of the underlying data.
- The savings, once calculated, should not be overstated, nor should they be understated: the methodology must be reasonable and appropriately measure the impact of Dirigo on the rate of growth in the health care system.
- The methodology for savings calculations must be transparent, meaning the savings are calculated using the data available, the methodologies as best as possible laid out in this report, and savings amounts verified through worksheets contained in a final report when data is available.
- When calculated, the savings will be used to sustain DirigoChoice at no additional costs.

Q: Why are there so many different time frames and savings methodologies?

A: The Statute does not set out a single population or timeframe to measure the savings, therefore there cannot be a single methodology. For example, for the Year 2 Hospital Initiative, the Maine Hospital Association, on behalf of its member hospitals, agreed to voluntarily limit increases in costs per case-mix adjusted discharge to 4.5% covering state fiscal years beginning on or after July 1, 2004 through June 30, 2005. For the Uninsured Initiatives, the avoidance of bad debt and charity care will only come about as a result of enrolling previously uninsured and under-insured individuals in new health care coverage. Thus, the Uninsured Initiatives only apply to previously uninsured and under-insured individuals, and for purposes of the Year 2 calculation, it applies to the time period covering January 1, 2006 through December 31, 2006. Because these are two different populations and two different time periods, it would not be accurate or reasonable to use a single measure, nor would it be consistent with the statute. In a similar manner, in order to capture the full impact of Dirigo and meet the statutory obligation for the Year 2 savings calculation, it required 9 different initiatives to reflect the aggregate, measurable cost savings, which were reasonably supported by readily available data and information.

Q: Mr. Schramm, can you generally describe the four major types of savings initiatives for Year 2?

A: The first major area for savings, the Hospital Savings Initiatives come from the Dirigo Act, which initially asked each hospital to voluntarily hold consolidated operating margins (COM) to no more than 3% for the hospital’s fiscal year

beginning July 1, 2003 and ending June 30, 2004 and to voluntarily restrain cost increases, measured as costs per case mix adjusted discharge (CMAD), to no more than 3.5% for the same time period. The Legislature re-authorized the COM and CMAD limits for the July 1, 2005 thru June 30, 2006 time period. For the intervening year, July 1, 2004 to June 30, 2005 (Year 2 for Hospital Savings Initiatives), the Maine Hospital Association, only imposed a voluntary limit for CMAD of 4.5%. As MHA did not agree to a voluntary limit for COM for Year 2, Mercer only established a Year 2 savings methodology for CMAD based on MHA's voluntary limit of 4.5%. See Schramm Exhibit 3.

The statute also asks the cooperation of health care practitioners in controlling the growth of insurance and health care costs. In keeping with the guiding principles described in detail in our report, data is not readily available at this time to estimate the impact of other health care practitioners' voluntarily limiting the growth of insurance and health care costs. As a result, Mercer did not include an estimated impact in the first assessment year or in this, the second assessment year.

The second major area for the Year 2 savings methodologies are the Uninsured Savings Initiatives. Savings Offset Payments are to reflect aggregate measurable cost savings, including any avoidance of bad debt and charity care cost to health care providers in this State, as a result of the operation of Dirigo Health and any increased enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004. The key language here is, "including any avoidance of bad debt

and charity care." According to the Maine Hospital Study Commission, the uninsured and the under-insured are responsible for a significant portion of the bad debt and charity care incurred by hospitals in the State of Maine. The cost of increased bad debt and charity care is ultimately borne by private payers in the form of cost-shifting and resulting rate increases to cover bad debt and charity care. As a result, any previously uninsured or under-insured individuals who receive insurance coverage as a result of the Dirigo program will result in the reduction of bad debt and charity care and, and in savings to the system through a reduction in cost-shifting to private payers. Mercer identified two potential areas of savings as a result of taking previously uninsured and under-insured individuals and providing them with health insurance. The first uninsured savings opportunity comes as a result of direct enrollment in the DirigoChoice program — reduction in bad debt and charity care due to previously uninsured individuals now being covered under the DirigoChoice program, and — reduction in bad debt and charity care due to previously under-insured individuals now enrolled in the DirigoChoice program. The second potential area for uninsured savings comes from the enrollment of individuals previously uninsured or under-insured seeking out health insurance (other than the DirigoChoice program) that is due to the increased publicity and awareness of the value of health insurance, known as the "woodwork effect". States that have undertaken major health reform initiatives as sweeping as Dirigo's have seen substantial increases in their Medicaid/SCHIP and private health insurance enrollment. Thus, there is a reduction in bad debt and charity care due to previously uninsured individuals now enrolled in the

MaineCare programs (MaineCare Woodwork). This can be due to either increases in Maine's specific eligibility, such as the MaineCare Adult Expansion or increases in Maine's overall eligibility counts through increased enrollment due to the sentinel effect of Dirigo. There can also be a reduction in bad debt and charity care due to previously uninsured individuals now enrolled in private insurance (Private Insurance Woodwork). As with the voluntary limits to physician cost increases described above, data is not readily available to determine the impact of the Private Insurance Woodwork and so Mercer has not included a savings methodology for Year 2.

The third major area of initiatives for the Year 2 savings methodologies are the Certificate of Need (CON) and Capital Investment Fund (CIF) Savings Initiatives. The CON and CIF initiatives provide savings by reducing the need for cost increases to the private payer. Due to the implementation of a moratorium on hospital CON and non-hospital CON spending and the implementation of a CIF which limits spending on new capital projects, both of which substantially reduce the amount of hospital spending, the need for payer rate increases is reduced. First, there is a reduction in hospital costs due to the CON moratorium and the CIF limits, and, second, there is a reduction in non-hospital costs due to the CON moratorium and the CIF limits.

The fourth area for Year 2 savings methodologies are the Health Care Provider Fee Savings Initiatives. Similar to the Uninsured Initiatives, these initiatives

identify savings that occur in the health care system due to reductions in cost shifting. According to the Hospital Study Commission, hospital and other health care providers must cost-shift to private payers to make up for the difference between Medicaid funding and costs. Thus, increased funding from Medicaid will reduce the need for cost-shifting to private payers. Therefore, savings will accrue to private payers as the need for cost increases from other payers will be reduced as additional cash is received by hospitals and physicians. There will be reductions in cost-shifting due to hospitals receiving funds earlier, and a reduction in cost-shifting due to increased funding for physicians.

Q: Mr. Schramm, tell us about the process Mercer used to develop your methodologies.

A: In establishing the savings methodologies, as mentioned above, we developed a set of principles to guide our process. One of the key guiding principles was that the data sources used must be readily available, verifiable and auditable, and to the extent possible, used for other purposes as well. At this point in time, not all of the relevant data necessary to calculate the Year 2 savings amounts are available. However, at the request of the Hearing Officer, we have estimated savings based on the available data and those savings estimates are included in our April 2006 report to the Board. For Year 2, we also have the input provided by the Superintendent of Insurance in his review of the Year 1 savings methodologies to guide our process. Where appropriate, Mercer made changes to

the guidelines suggested by the Superintendent and noted our changes accordingly.

Q: Can you clarify the reason why all the data is not available at this time? The May hearing date is even later than that anticipated within the Statute, shouldn't everything already be in?.

A: The April 1st date in the original legislation was based on an assumed start date for Dirigo of July 1st. As was show by the Year 1 process, the data is not readily available for a January 1st start date until well into the middle of the calendar year. One of our guiding principles is that the data be readily available, verifiable and auditable, and to the extent possible, used for multiple purposes to ensure the accuracy of the underlying data. Let's apply that principle to the MCRs, which are the primary data source for the CMAD calculation. The Interveners would have you believe that only a very small portion of the MCRs were unavailable in February — in their testimony at the Board hearing addressing Dirigo's request for a continuance, they publicly stated that only very small percent of the data was unavailable based on Medicare filing regulations. In fact, that was not the case, was indeed very misleading and not at all accurate. During the Year 1 testimony, Dirigo established that the publicly available data source (again one of our guiding principles) for MCR's is the Maine Health Data Organization (MHDO). In the State of Maine, when hospitals file their MCRs with MHDO, they also file a copy with Maine's Office of Audit at the Department of Health and Human Services. To verify the accuracy of the Interveners' testimony concerning which

data is currently available, we requested a listing of the MCRs currently available for hospital fiscal year 2005. According to State of Maine's Office of Audit, of the 36 hospitals that MHA agreed to for use in the Year 1 savings methodology and subsequent year's savings methodologies, only 19 had fully submitted their MCRs by March. Those 17 hospitals that had not fully submitted their MCRs represented 69% of total hospital expenditures in the Year 1 calculation and 61% of the savings in Year 1, hardly an "insignificant" percentage as the Interveners testified to the Board and the Hearing Officer. At that point in time, 69% of the source data for the CMAD calculation has not been fully submitted. Thus, one cannot take at face value what data "should" be available. Instead, one must go through the process to verify what data is currently available and that process takes time. In addition, the application of the savings methodologies is an extremely complex undertaking and sufficient time must be allocated to ensure that the data is utilized correctly and the methodology applied appropriately.

Q: Let's now move to the specific initiatives and calculations for which you will provide testimony. Can you describe those initiatives?

A: Yes — I will provide testimony on three of the initiatives: 1) the Hospital Savings Initiative measuring reductions in the rate of increase in cost per case-mix adjusted discharge (CMAD), 2) the Certificate of Need (CON) and Capital Investment Fund (CIF) Savings Initiatives measuring reductions in both hospital and non-hospital CON/CIF projects; and 3) the Health Care Provider Fee Savings

Initiatives measuring increases in the rate of reimbursement for hospitals and physicians.

First is the hospital savings initiative that measures the impact of the hospitals in Maine voluntarily limiting their rates of increase in their costs per case-mix adjusted discharge to only 4.5% for July 1, 2004 to June 30, 2005. To understand the Year 2 savings methodology for CMAD, it is necessary to describe the Year 1 process.

For Year 1, to determine if savings resulted from the voluntary CMAD target, it was necessary to first blend each hospital's fiscal year (HFY) data together to create a cost per discharge figure for each hospital on a state fiscal year 2000 (SFY00) basis. Then each hospital's projected SFY03 cost per discharge was estimated from SFY00 costs by trending forward the SFY00 cost per discharge amounts by the annual HMBI increases. The projected SFY03 costs were compared to the actual SFY03 (blended) costs to determine each hospital's cost per discharge growth rate above inflation. SFY04 CMAD was estimated using a hospital's cost growth rate above inflation and compared to the hospital's actual SFY04 (blended) cost per discharge. Year 1 savings were calculated when the difference between the SFY04 estimated cost per discharge and the actual SFY04 (blended) cost per discharge was positive. Summing this cost per discharge savings across all discharges and all hospitals yielded total savings for the voluntary CMAD target for Year 1.

There are 4 potential scenarios where savings could have occurred in Year 1 for a hospital, using the Year 1 voluntary CMAD limit of 3.5%. Mercer's approach in Year 1 was conservative and only estimated savings derived from the first two scenarios:

1. Hospital baseline trend was above 3.5% and SFY04 trend was below the baseline. Positive savings can be directly measured in Scenario #1.
2. Hospital baseline trend was below 3.5% and SFY04 trend was below the baseline. Positive savings can be directly measured in Scenario #2
3. Hospital baseline trend was above 3.5% and SFY04 trend was above the baseline. For positive savings to be measured in Scenario #3, an indirect counter-factual analysis would have been necessary to determine if the SFY04 trend would have been higher in the absence of Dirigo.
4. Hospital baseline trend was below 3.5% and SFY04 trend was above the baseline. For positive savings to be measured in Scenario #4, an indirect counter-factual analysis would have been necessary to determine if the SFY04 trend would have been higher in the absence of Dirigo.

To understand Mercer's methodology, it is helpful to look not only at opportunity for savings, but also for the other potential outcomes, depending upon where a particular hospital's SFY04 was compared to the baseline. Mercer identified 4 outcomes depending upon where a particular hospital's SFY04 was compared to the baseline.

For hospitals where SFY04 trend is lower than baseline trend:

Outcome A) Scenarios 1 and 2 above yields positive savings

Outcome B) Normally occurring fluctuations in CMAD yields negative savings

For hospitals where their SFY04 trend is higher than baseline trend:

Outcome C) Normally occurring fluctuations in CMAD yields positive savings

Outcome D) Scenarios 3 and 4 above yields negative savings

Mercer's Year 1 Methodology estimated savings only from option A); positive savings as a result of measurable reductions in CMAD. The testimony during the Year 1 adjudicatory hearing clearly established that Dirigo was the primary driver of positive savings in option A, representing Scenarios 1 and 2. The testimony also clearly established that Dirigo was ***not*** the primary driver of negative savings in option D, representing Scenarios 3 and 4.

In fact, the testimony established that nothing in the Dirigo legislation would cause an increase in costs (and thus negative savings) as measured by Outcome D. Mercer assumed that, at a minimum, a similar relationship existed between Outcomes B and C. Mercer assumed, at a minimum, the savings component in Outcome B (which is negative overall) would be at least as large in magnitude as the savings component in Outcome C (which is positive overall).

This assumption was borne out as reasonable, as testimony clearly established that Dirigo was the primary driver behind positive savings in the system and had no impact on negative savings. Thus, Mercer's methodology, based on positive savings from Outcome A and implicitly accounting for random fluctuations by

assuming Outcomes C and D at a minimum cancel each other out, was reasonable.

The Superintendent's Year 1 savings methodology was concerned with controlling for normally occurring fluctuations and so included both Outcomes A and D in an attempt to control for those fluctuations and determine savings due to Dirigo. The Superintendent's methodology effectively provides equal weights and equal probabilities to the Dirigo impacts in Outcomes A and D. However, as noted above, the testimony clearly showed this was not the case — Dirigo was the driver for Outcome A but had no impact on Outcome D.

Thus, the Superintendent's methodology of netting Outcomes A and D unnecessarily reduces the savings attributed to Dirigo, contrary to the testimony, in an attempt to control for normally occurring fluctuations in CMAD.

Based on the above and using the Superintendent's decision on Year 1 savings as guidance, Mercer modified the CMAD savings methodology for Year 2.

To address the Superintendent's concern about Mercer's Year 1 methodology not factoring in normally occurring fluctuations in CMAD, Mercer has designed a methodology for Year 2 that includes all four Outcomes: A, B, C, and D. In Mercer's Year 2 methodology, we apply Year 1's approach to determining individual hospital CMAD experience and then go a step further in Year 2 by

summing all hospitals' experience to determine a Statewide aggregate CMAD pre- and post-Dirigo.

This additional step of summing all of the hospitals' individual CMAD experience includes *all* of the experience — Outcomes A, B, C, and D. Mercer's Year 2 methodology for CMAD addresses the concerns raised by the Superintendent by controlling not only for positive savings (Outcome A), but also for normally occurring fluctuations (Outcomes B and C), as well as negative savings (Outcome D).

Finally, to address a concern raised by the Superintendent about determining savings across inconsistent time periods, Mercer will apply an interest factor to adjust the savings to a consistent present value.

Below is the process Mercer will take in order to determine if there are overall aggregate CMAD savings in Year 2 once all of the data is available:

1. Combine HFY data for each hospital as necessary to put all hospitals on a SFY basis;
2. Sum the appropriate revenues and expenses across all hospitals to determine system-wide revenues and expenses, then calculate Statewide CMAD figures for SFY00 through SFY05;

3. Project the SFY03 CMAD system-wide from the SFY00 CMAD trended forward using the HMBI for each year to SFY03; compare this projected SFY03 CMAD to the actual SFY03 CMAD and calculate the pre-Dirigo annual rate of increase beyond inflation in the HMBI;
4. Project the SFY05 CMAD using the actual SFY03 CMAD, HMBI trends, and the pre-Dirigo annual rate of growth above inflation;
5. Compare the projected Statewide SFY05 CMAD with the actual Statewide SFY05 CMAD; savings are calculated as the difference of the projected system-wide figure compared to the actual;
6. Multiply the savings per CMAD by the total Maine hospital discharges in SFY05 to arrive at our final savings number; and
7. Apply interest to the savings amount to put it on a consistent time period with the other savings calculations.

Next are the CON and CIF Savings Initiatives. Similar to the Uninsured Savings Initiatives, there is not a specific target associated with the reduced spending due to the CON or CIF Initiatives, but instead savings can be measured due to the reduction in the need for cost-shifting to private payers. As this spending is reduced, the need for payer rate increases is reduced. Our methodology estimates savings associated with the moratorium on hospital and non-hospital spending that started May 1, 2003, and the implementation of the CIF which limits the hospital and non-hospital capital spending beginning January 1, 2005. This methodological description replaces that included within Mercer's March 2006

report to the Dirigo Board on the Year 2 Savings methodologies. Due to the compressed time frames and lack of available data resulting from the Hearing Officer's request to have all calculations submitted by May 2nd for the May 8th hearing, Mercer must submit a methodology that would provide savings estimates based on available data.

At this time, the CON/CIF process corresponding to Year 2 of the Savings Offset Payment is not complete. It is not currently known which projects will be approved or disapproved under the CY06 CIF limit as the final Board action is not anticipated to be completed until May 2006 at the earliest. However, based on what has been submitted and modified, we can provide the Board with an initial savings estimate per the Hearing Officer's request. First, we do know that savings have occurred as there were applications that were re-filed at lesser dollar amounts to avoid the dollar thresholds for review that are part of the CON/CIF process. Second, due to the existence of the CY06 CIF limit, not all of the projects submitted can be approved — the total dollars submitted exceeds the CY06 limit. Thus, savings will result from the denial of at least some of the large hospital projects that must be denied. Potential savings scenarios were determined based on all of the possible combinations of the large hospital projects that could be approved or rejected. For purposes of the savings estimate provided in April 2006 report to the Board, Exhibit 3, Mercer has chosen the least amount of savings available based on the potential combinations of approvals/rejections.

In addition, we have incorporated the Superintendent's suggestion of incorporating a present value adjustment to our Year 2 savings estimates.

Q: Mr. Schramm, you noted in your testimony for the Year 2 savings methodology for CMAD you differed from the Superintendent's guidelines. Did you differ from the Superintendent's guidelines in establishing the savings methodology for CON/CIF?

A: Yes, for Year 1 the Superintendent found that the random fluctuations in the CON/CIF process precluded determining a savings estimate for the impact of the Dirigo program. To address this, as noted above, Mercer's revised approach for Year 2 looks at the entirety of the CON/CIF process — Letters of Intent, Technical Assistance Sessions, Applications, and Approvals for all hospital and non-hospital CON projects for the time period 07/01/1998 – 06/30/2006. In this way, we will have a larger, more robust data set that looks at all of the steps within the State of Maine's CON/CIF process, not just the snapshot of approved projects utilized in Year 1. In addition, we will determine an average cost for all projects combined over the full time period, thus removing any annual random fluctuations.

Q: Mr. Schramm, are there other initiatives for which you will provide testimony?

A: Yes, I will also address the Health Care Provider Fee Initiatives. The Health Care Provider Fee Initiatives are again similar to the Uninsured and CON/CIF Initiatives in that there is no specific target described in the legislation. Instead,

these initiatives measure savings to the system as a result of a reduction in the need for cost-shifting to private payers. This reduction in cost-shifting, due to Health Care Provider Fee Initiatives, comes about in two ways. The first, reduction in cost-shifting and resulting savings to private payers, comes from an infusion of money earlier than expected into the hospital system which reduces the hospitals' need for cost increases from private payers. Our savings methodology measures the time value of additional PIP money 3 years earlier than in the past. Additional money will be paid in CY06 to hospitals in their weekly installments and not have to wait 3 years or more to get it during the settlement process. The cost-shifting will be reduced due to the "time value of money". Based on the Superintendent's guidance, Mercer will only include the time value of money for PIP increases in CY06 and the actual increase in cash payments to physicians in CY06.

To determine the impact of the hospital and physician fee initiatives, Mercer used the methodology below for Year 2.

1. Confirm hospital Prospective Interim Payment (PIP) increases and increased physician payments to be paid in CY06.
2. Calculate the time value of receiving the PIP increases early so hospitals do not have to borrow or use other funds. An updated interest rate has been used to reflect the appropriate time periods.
3. Calculate the amount of additional physician money available. Add #2 and #3 to determine total savings for this initiative.

Q: Mr. Schramm, are there any changes you wish to make to Schramm Exhibit 2 or 3?

A: I would note that Mercer has several references to include in support of the "woodwork effect" that Mr. Russell discusses in his testimony. In addition, on page 16 of the Mercer report, Step 6 should read as follows "6. Multiply the savings per CMAD by the total Maine hospital *discharges* in SFY05 to arrive at our final savings number; and". As noted previously in this testimony, due to the reduced the time frames associated with the May 8th hearing date, Mercer had to revise the CON/CIF to be based on the currently available data.

Q: Mr. Schramm, do you adopt Schramm Exhibits 2 and 3, as revised, as part of your testimony?

A: Yes — I do.

Dated: May 1, 2006

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STEVEN P. SCHRAMM

STATE OF MAINE

DIRIGO HEALTH AGENCY

RE: DETERMINATION OF AGGREGATE MEASURABLE COST SAVING FOR THE SECOND ASSESSMENT YEAR (2007)	))))))	AMENDED PRE-FILED TESTIMONY OF F. KEVIN RUSSELL

F. Kevin Russell called as a witness by the Dirigo Health Agency, testifies as follows:

Q: Please state your name, occupation, employer, and business location.

A: My name is F. Kevin Russell. I am a consulting actuary and a principal in Mercer's Government Human Services Consulting Practice (Mercer). My office is located in Phoenix, Arizona.

Q: Mr. Russell, please describe your educational and professional background.

A: My educational and professional background is set forth in the attached curriculum vitae, Russell Exhibit 1. As an actuary for the Mercer, I have had primary actuarial involvement in the financial analysis and/or managed care rate development for publicly sponsored health care programs in a number of states. Also, let me be clear that my testimony today is for my work at Mercer on the Dirigo program; I am not speaking on behalf of the American Academy of Actuaries.

Q: Mr. Russell, did you participate in the preparation of Mercer's reports, which are labeled Schramm Exhibits 2 and 3?

A: Yes, I did.

Q: I am going to show you these Exhibits. Are these the reports you are referring to?

A: Yes, they are.

Q: On which of the initiatives identified in the reports will you be providing testimony?

A: I will testify on the Uninsured Savings Initiatives.

Q: Mr. Russell, can you describe those initiatives?

A: Yes. These initiatives come directly from the Dirigo Act, which states that savings offset payments must reflect aggregate measurable cost savings, including any avoidance of bad debt and charity care cost to health care providers in this State, as a result of the operation of Dirigo Health and any increased enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004. The savings follow from a reduction in the need for cost-shifting, such as that which comes from a reduction in bad debt and charity care.

Q: What do you mean by cost-shifting?

A: When a provider, such as a hospital or physician, perceives that reimbursement from a source (such as the self-pay (uninsured), Medicare, or Medicaid) is insufficient, the provider may seek to charge its other customers (those covered by commercial insurance) higher amounts to make up for the perceived insufficiency.

Q: Thank you. Please continue.

A: The Uninsured Savings Initiatives are a measurement of the indirect savings, which result from a reduction in the need for cost-shifting. The need for cost-shifting is reduced when hospitals need to charge private payers for the bad debt and charity care of the uninsured and under-insured is reduced. Mercer identified five potential savings initiatives, but was only able to provide estimated impacts for four of those initiatives in Year 2.

Q: What are those initiatives?

A: The four initiatives for which Mercer estimated the impact of the Dirigo program are: 1) reduction in bad debt and charity care due to the previously uninsured enrolling in DirigoChoice; 2) reduction in bad debt and charity care due to the previously under-insured enrolling in DirigoChoice; 3) reduction in bad debt and charity care due to the previously uninsured enrolling in MaineCare's specific eligibility expansion, MaineCare Adult Expansion; and 4) reduction in bad debt and charity care due to the previously uninsured enrolling in MaineCare/SCHIP, as a result of publicity connected with the Dirigo enrollment process. This is commonly called the "woodwork effect." In keeping with our guiding principles, consistent up-to-date data is not readily available at this time to estimate the impact of the increase in private insurance. Therefore, Mercer has not included an estimated impact in Year 2.

Q: Please explain what you mean by "woodwork effect."

A: The "woodwork effect" is a term describing the eligibility expansion in Medicaid and SCHIP programs not due to changes in the number of persons eligible by reason of income, but rather from those persons eligible but not enrolled although they meet the requirements (other than not having made application). The increase in publicity and/or new enrollment procedures results in these persons coming "from out of the woodwork" to make application and become enrolled. The February 2001 report by the Office of Inspector General for the Department of Health and Human Services entitled "State Children's Health Insurance Program: Ensuring Medicaid Eligibles are not Enrolled in SCHIP" has the following on page 3: "…Title XXI requires States to screen SCHIP applicants for Medicaid eligibility. … Due to their efforts to enroll children in new Title XXI funded programs, some States have noticed the so-called 'woodwork effect'; by conducting outreach for SCHIP, they encourage greater numbers of Medicaid eligibles to apply for health care services as well." In March 2003, Mathematica Policy Research, Inc. submitted to CMS a report entitled "Implementation of the State Children's Health Insurance Program: Synthesis of State Evaluations, Background for the Report to Congress." The following is taken from pages 183 through 185 of the report. "In discussing their progress toward reducing the number of uninsured, low-income children, many states emphasized the 'spillover effect' of SCHIP outreach on the enrollment of eligible children in Medicaid. This phenomenon is often called the 'woodwork effect'—that is, where children who have long been eligible for Medicaid became enrolled as a direct result of new outreach and eligibility simplification initiatives under SCHIP. "…In some states, Medicaid enrollment attributable to SCHIP actually exceeded the level of SCHIP

enrollment. …" Continuing with excerpts relating to specific states, in Arizona, "Medicaid enrollment accounted for 47 percent of total enrollment due to KidsCare outreach efforts." Also, "Kansas estimated that 17,800 children had enrolled in Medicaid as of March 2000, as a result of the HealthWave (SCHIP) application process. This exceeded the number enrolled in SCHIP—16,040 as of March 2000." Also, "New Jersey estimated that two children enrolled in Medicaid for every three that enrolled in SCHIP." All of these are demonstrable examples of the "woodwork effect" associated with major health policy reforms directed at reducing the rate of uninsurance at a state level.

Q: Mr. Russell, Mr. Schramm testified that Mercer established principles to guide your process for developing the savings methodologies in Year 1 and that for this year, Year 2, Mercer included an additional guiding principle; to the extent possible, methodologies for Year 2 will be consistent with the guidelines provided by the Superintendent in regards to the Year 1 methodologies. Can you tell me how this impacted your savings methodologies for the Uninsured Savings Initiatives?

A: Certainly, for the Uninsured savings methodologies in Year 1, the Superintendent's Order said that Dirigo should adjust the charge-based savings amounts to account for providers not realizing full charges when the previously uninsured have insurance coverage under which the providers have agreed to a discount off their full charges. Mercer's Year 2 methodology includes such an adjustment.

Q: Mr. Russell, did you differ from the guidelines provided by the Superintendent in regards to the Year 1 methodologies?

A: Yes, the Superintendent's Order said that the "woodwork effect" "was not reasonably supported by the evidence," so the savings for the "woodwork effect" was not included by the Superintendent in the Year 1 amount deemed reasonably supported. For Year 2, Mercer's "woodwork effect" component of the Uninsured Savings Initiatives is based on a revised methodology where calculations are done for two groups of the MaineCare eligibles. The first savings calculation is based on the total enrollment of the Medicaid Expansion Parents since July 1, 2005; this MaineCare group is directly referenced in the statue, so therefore, directly as a result of Dirigo. The second calculation is for those that complete a Dirigo application, but are later deemed eligible for MaineCare. Therefore, these are counts of people that hear about Dirigo, come in and apply, but are deemed Medicaid eligible. In other words, these are individuals that come out of the "woodwork" and we have now been able to include a direct count.

These "woodwork" persons would have been individuals or sole proprietors in Dirigo, except that they were eligible for MaineCare. They were enrolled in MaineCare, not Dirigo. These "woodwork effect" persons are measured directly and they are not inferred from enrollment changes that compared projections based in pre-Dirigo trends in reenrollment. The Dirigo Health Agency may be able to identify more such persons in the future. In such cases, the calculation would be updated to incorporate the latest data. Note that the A group of Dirigo enrollees is also Medicaid-eligible. These are small employer enrollees. They are

Medicaid eligible, so they receive the 100 percent premium subsidy. They are, however, enrolled in Dirigo, and not counted as “woodwork” persons.

Q: Mr. Russell, are there any changes you wish to make to your portions of the Mercer reports?

A: None other than the inclusion of the cited “woodwork effect” references that I mentioned earlier in this written direct testimony.

Q: Mr. Russell, do you adopt the portions of Schramm Exhibits 2 and 3 concerning the Uninsured Savings Initiatives as part of your testimony?

A: Yes, I do.

Dated: May 1, 2006

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F. KEVIN RUSSELL

STATE OF MAINE

DIRIGO HEALTH AGENCY

IN RE: DETERMINATION OF AGGREGATE MEASURABLE COST SAVING FOR THE SECOND ASSESSMENT YEAR (2007)	)))))	PRE-FILED TESTIMONY OF CATHERINE M. COBB

Catherine M. Cobb called as a witness by the Dirigo Health Agency, testifies as follows:

Q: Please state your name, occupation, employer, and business location.

A: My name is Catherine M. Cobb. I am currently employed by the State of Maine as Director of the Division of Licensing and Regulatory Services within the Department of Health and Human Services in Augusta, Maine.

Q: Ms. Cobb, please describe your roles and responsibilities within your current position.

A: As the Director of the Division of Regulatory Services with the State of Maine, Department of Health and Human Services, I have responsibility for licensing, certification or registration of more than 5,400 health related facilities in the state. In addition, I have responsibility for the operation and oversight of Certificate of Need (CON), which is limited by the Capital Investment Fund (CIF) within the State of Maine. In my employment with the State of Maine, I have worked on CON issues since 1996 and have participated in all of the key phases associated with the CON process: establishment of rules governing CON, submission of projects, evaluation of projects, and approval of projects.

Q: Ms. Cobb, did you participate in the development of savings methodologies that are included within the March Mercer report, which is labeled Schramm Exhibit 2?

A: Yes, I did.

Q: I am going to show you Schramm Exhibit 2. Is this the report you are referring to?

A: Yes, it is.

Q: Ms. Cobb, did you participate in the development of the savings methodologies update and preliminary calculations which are included within the May Mercer report, which is labeled Schramm Exhibit 3?

A: Yes, I did.

Q: I am going to show you Schramm Exhibit 3. Is this the report you are referring to?

A: Yes, it is.

Q: On which of the initiatives identified in the report will you be providing testimony?

A: I will testify on CON and CIF Savings Initiatives.

Q: Ms. Cobb, can you describe that savings methodology?

A: Yes. The methodology estimates savings associated with the moratorium on hospital and non-hospital spending that started May 1, 2003, and the implementation of the CIF which limits the hospital and non-hospital capital spending beginning January 1, 2005. This methodological description replaces that which is included within Mercer's

March 2006 report to the Dirigo Board on the Year 2 Savings methodologies. The revised methodology is solely based on measurable reduced spending, which is the primary intent of CON & CIF. It takes place in a two-step process.

First, we reviewed CON submissions that were subsequently revised and withdrawn by large hospitals. The hospitals reduced the scale of the project to fall below the third year threshold for operating costs. (Please note that by lowering third year operating costs, projects were implemented by the health care facility without CON approval at a reduced cost). We then subtracted the initial third year costs from the third year limit to arrive at savings for each of these large hospitals.

The second step of our approach is limited by the fact that the current CON/CIF approval process for 2006 is not complete. Therefore, we cannot determine the total value of savings at this point in time. We plan to have decisions made in June so it is possible to have savings calculated in the June time period for large hospital projects. We do know that, at this time, the total value of the submitted large hospital projects exceeds the available CIF amount. Therefore, there will be savings since the State will have to deny some of the large hospital projects solely on the basis of the remaining CIF credits. It is also possible that projects may be denied solely on their merits. In order to provide preliminary savings for this hearing, we created a model of all possible CON approvals and rejections within the threshold level and selected the one with the least amount of savings. In other words, we were very conservative in this savings estimate and reserve the right to go back and calculate a better estimate of savings prior to the Superintendent's review of the Year 2 Savings.

It should be noted that we applied present value to each of the above steps to bring the savings calculation from the estimated 3rd year of operation back to CY 2006. We did this based on feedback from the Superintendent's ruling of the Year 1 Savings.

The combination of steps #1 and #2 above result in **preliminary** savings figures for the CON/CIF initiative. Final savings will be calculated for Step #2 above after June 1, 2006 when all of the approved large hospital projects for 2006 have been completed.

Q: Ms. Cobb, how have you mitigated against the opportunity for over-estimating these preliminary numbers?

A: In two ways: in Step #1 above we are calculating savings only on those hospitals that withdrew their requests for CON, and proceeded with the projects and at a reduced cost. We do not know how many other hospitals submitted, or planned to submit, a request for CON, withdrew and did so due to the more stringent CON/CIF approval process. We are not attempting to count or determine these withdrawal values as savings.

Also, in Step #2 above, we have selected the combination of large hospitals that, if approved, would result in the least amount of savings. In reality a different set of hospitals could actually be approved and the savings will be greater. This selected combination of projects reflects only the mathematical reality of the CON/CIF approval process. This is not necessarily the combination of projects that I expect will be approved. Therefore, both of the above calculations target conservative savings. The final figures will be provided after June 1, 2006.

Q: Ms. Cobb, are there any changes you wish to make to your portions of the Mercer report?

A: None.

Q: Ms. Cobb, do you adopt the portions of Schramm Exhibit 2 and Schramm Exhibit 3 concerning the CON/CIF Savings Initiatives as part of your testimony?

A: Yes, I do.

Dated: May 1, 2006

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CATHERINE M. COBB

STATE OF MAINE

DIRIGO HEALTH AGENCY

RE:	DETERMINATION OF AGGREGATE MEASURABLE COST SAVING FOR THE SECOND ASSESSMENT YEAR (2007)	))))))	PRE-FILED TESTIMONY OF LEONARD BRAUNER

Leonard Brauner, called as a witness by the Dirigo Health Agency, testifies as follows:

Q: Please state your name, employer and business location.

A: My name is Leonard Brauner. I am a consulting Certified Public Accountant and Principal at SunStone Consulting, LLP (SunStone). My office is located in New York, New York.

Q: Mr. Brauner, please describe your educational and professional background.

A: My educational and professional background is set forth in the attached curriculum vitae, Brauner Exhibit 1. SunStone Consulting assists healthcare providers throughout the United States with reimbursement, regulatory and strategic solutions in reimbursement and cost reporting. We work with university teaching hospitals, large health systems, small community hospitals, inpatient specialty providers, critical access hospitals, skilled nursing facilities and outpatient clinics to assure that they receive the reimbursement that they deserve, and no more, while complying with all guidelines and regulations.

As a Principal with SunStone, I have been primarily involved with the preparation, auditing and analysis of Medicare Cost Reports (MCR) for all types of providers, primarily hospitals. I have nearly 30 years of experience in the health care industry, including 22 years of diversified healthcare financial consulting including Medicare and all payer reimbursement, charging and billing compliance and all forms of patient charge processes.

Q: Mr. Brauner, please describe generally the work SunStone did on behalf of the Dirigo Health Agency.

A: SunStone assisted the Dirigo Health Agency, and their consultants, Mercer Government Human Services Consulting establish the correct data from a hospital's MCR to be used in the cost per case-mix adjusted discharge (CMAD) savings calculations initiative. Our work with the Agency and Mercer included review of the Dirigo Year 1 savings offset payment calculations, the Dirigo Year 2 savings offset payment calculations, review of the MCR components that were factored into the Year 2 calculations and review of the final CMAD savings figures. Our sole purpose for reviewing the above documents was to determine whether the data used from the MCRs was appropriate as based on the source of the data and its purpose within the Year 2 calculation.

Q: Mr. Brauner, did SunStone assist the Dirigo Health Agency or Mercer with the development of any of the Year 2 savings offset payment methodology or calculations?

A: No. Our sole purpose for reviewing the MCR components that were factored into the Year 2 calculations, and review of the final CMAD savings figures, was to determine whether the data used from the MCRs was appropriate as based on the source of the data and its purpose within the Year 2 calculation.

Q: Mr. Brauner, did SunStone assist the Dirigo Health Agency or Mercer with the development or preparation of a report describing the saving methodology or calculation to be used for (CMAD) savings calculations initiative?

A: No. Our sole purpose for reviewing the MCR components that were factored into the Year 2 calculations, and review of the final CMAD savings figures, was to determine whether the data used from the MCRs was appropriate as based on the source of the data and its purpose within the Year 2 calculation.

Q: Mr.Brauner, are there other initiatives for which you will provide testimony?

A: No.

Dated: May 1, 2006

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LEONARD BRAUNER